Quality Measures Workgroup
Draft Transcript
April 26, 2012

Roll Call

Operator

All lines are now bridged.

MacKenzie Robertson – Office of the National Coordinator

Thank you. Good morning everyone, this is MacKenzie Robertson in the Office of the National Coordinator. This is a meeting of the HIT Policy Committee's Quality Measures Workgroup. This is a public call and there will be time for public comment at the end. The call is also being transcribed so please make sure you identify yourself when speaking. I'll now go through roll and at the end ask any staff members to identify themselves. David Lansky?

David Lansky – Pacific Business Group on Health – President & CEO

Here.

MacKenzie Robertson – Office of the National Coordinator

Tripp Bradd?

Tripp Bradd – Skyline Family Practice, VA

Present.

MacKenzie Robertson – Office of the National Coordinator

Russ Branzell? Helen Burstin? Neil Calman? Carol Diamond? Tim Ferris? Patrick Gordon? Can I just ask anyone listening through their phone to please mute their computer speakers if they also have them on? Timothy Ferris? Patrick Gordon? David Kendrick? Charles Kennedy? Karen Kmetik? Robert Kocher? Marc Overhage? Laura Petersen?

Laura Petersen – Baylor University

Here.

MacKenzie Robertson – Office of the National Coordinator

Eva Powell?

Eva Powell – National Partnership for Women & Families

Here.

MacKenzie Robertson – Office of the National Coordinator

Sarah Scholle? Cary Sennett? Jesse Singer? Paul Tang? Kalahn Taylor-Clark? James Walker? Paul Wallace? Mark Weiner? Karen Goodrich? Daniel Green? Bob…? Steve Soloman? Peter Lee? Marsha Lillie-Blanton? Jon White? Westley Clark? Carolyn Clancy? Niall Brennan? Tony Trenkle? …? Norma Lang?

Norma Lang, RN – University of Wisconsin

Here.

MacKenzie Robertson – Office of the National Coordinator

Are there any staff members on the line that can please identify themselves?

Kevin Larsen – Office of the National Coordinator

This is Kevin Larsen from ONC.

Mary Jo Deering, Ph.D – Senior Policy Advisor – Office of the National Coordinator for Health Information Technology

Mary Jo Deering, ONC.

Jesse James – Office of the National Coordinator

Jesse James, ONC.

MacKenzie Robertson – Office of the National Coordinator

Okay, thank you very much. David, if you are still on the line I'll turn it over to you or Eva if you've already dropped off?

David Lansky – Pacific Business Group on Health – President & CEO

No, I'm going to do a quick recap and intro.

MacKenzie Robertson – Office of the National Coordinator

Okay.

David Lansky – Pacific Business Group on Health – President & CEO

So, everyone, this is David, I'm sorry, I'm going to jump off the call in a minute; Eva has kindly agreed to facilitate the call. I think where we are at in the process is we've got a lot of good comments assembled that Kevin and Jesse have done a nice job putting together. A few important issues have bubbled up that have spawned side processes, which is great and Eva can summarize one of those that she has been leading around a potential measures development recommendation to CMS and another subgroup of vendors we've met with have made some additional recommendations which I think ultimately would actually integrate nicely with the proposal that Eva is suggesting.

We don't have time in the open comment period for the NPRM to fully think that all through but we may want to discuss whether in our comments to the HIT Policy Committee we want to make at least a suggestion that further work be done along those lines that Eva will summarize shortly that surfaced at our last call. So, I think our job now is to try to get to, what I really appreciate from you all, since I have to represent our discussions to the Policy Committee next Wednesday is getting a final sign off from us on what it is we want to say to the Policy Committee and hopefully in turn they will forward to CMS as part of the NPRM process, and so we want to get confirmation that we're saying the right things to the Policy Committee next week.

And, then in addition, consider these couple of new threads that Kevin can report on the vendor discussion and Eva on the measurement pipeline discussion and see if we have something there we want to relay to the Policy Committee as well. So, with that, I thank you all for your continued attention to this and help in formulating some recommendations and I will give it over to Eva to lead the discussion and I'm sorry to have to miss the rest of this, but thanks very much to everybody.

Eva Powell – National Partnership for Women & Families

Great, thanks, David, and thanks everyone who has joined. Kevin, I'm going to depend on you for a little bit of guidance here, is this a good juncture for me to just kind of launch into what I've been nittling on or is there other business we need to cover first?

Kevin Larsen – Office of the National Coordinator

Yeah, I think the main thing to cover, David mentioned, Josh and I had a little pre-call conversation, any of the members of the Workgroup we want you to look at the recommendations of the Workgroup to the Health IT Policy Committee as a spreadsheet, Quality Measure Workgroup response to NPRM MU2 and that is the document that we had talked about in our last call, and Jesse has done some more work to update it. If you want we can talk to any of the components of that on this call, otherwise we'll elicit you're

comments via e-mail and that work will eventually become the foundation of what David gives to the Policy Committee.

Eva Powell – National Partnership for Women & Families

Okay.

Kevin Larsen – Office of the National Coordinator

So, I don't know if you want to launch into that now, Eva, or do that later.

Eva Powell – National Partnership for Women & Families

That being walking through the comments in your spreadsheet?

Kevin Larsen – Office of the National Coordinator

Yeah, well, we've walked through the comments a number of times as a group.

Eva Powell – National Partnership for Women & Families

Okay.

Kevin Larsen – Office of the National Coordinator

So, it would be highlighting anything in the comments that the group wants to spend more time on.

Eva Powell – National Partnership for Women & Families

I gotcha. Okay, and the task at hand is basically to come up with a bulleted list for David to present at the full committee?

Kevin Larsen – Office of the National Coordinator

Yeah.

Eva Powell – National Partnership for Women & Families

Yeah, the full committee?

Mary Jo Deering, Ph.D – Senior Policy Advisor – Office of the National Coordinator for Health Information Technology

This is Mary Jo, if I could just make a point of clarification. We're actually going to have a different approach at the meeting next week, we're going to model what worked so successfully at the Standards Committee meeting and David will not have an individual presentation per se. We will take your comments and Michelle Nelson will be putting them into a common template that maintains the provenance of the comments so each Workgroup's comments on any particular item will be very clearly identified and then we'll just literally go through from, you know, from the top of the NPRM objectives and items all the way through and each Workgroup can speak to their individual comments very succinctly and concisely but they won't have an individual presentation. If there are materials that don't neatly fit into the template then they will be, you know, attached at the end and discussed separately. I hope that's helpful.

Jim Walker – Chief Information Officer – Geisinger Health System

Mary Jo, this is Jim Walker. The one thing I would add is that in Standards Committee there was a premium on chairs pointing out issues that Workgroups either identified as complex or problematic or, you know, where there was consensus and so I think it would perhaps help David if we were able at all to identify sort of the more important issues because he won't be able to sort of go through all of these points.

Mary Jo Deering, Ph.D – Senior Policy Advisor – Office of the National Coordinator for Health Information Technology

Thanks for that, that's a very good addition.

Eva Powell – National Partnership for Women & Families

Okay, so should we, just for the sake of offering opportunities to discuss things that need to be discussed on the spreadsheet and I've not had a chance to review it before the call, do we want to take just a couple of minutes for folks to look through it and then if there's anything they feel need to be discussed, we can sure do that?

Kevin Larsen – Office of the National Coordinator

That sounds like a great idea to me. The other thing I might suggest is if there's anything we should highlight as high priority for David we could have this group do that and we could be sure that those are starred or highlighted for him in a way that he could bring the importance to the Policy Committee.

Jim Walker – Chief Information Officer – Geisinger Health System

This is Jim, just as an example of that, if you look at the first box, you know, maybe the care coordination comment down at the bottom is the one that would sort of be called out in a policy meeting.

Eva Powell – National Partnership for Women & Families

Yeah, I would agree with that.

Kevin Larsen – Office of the National Coordinator

Will do.

Eva Powell – National Partnership for Women & Families

I think, at least in my mind, in the second box the issue of falls risk, because that's a measure that conceivably would go across provider settings that, that should be something that receive some element of priority and how David wants to make that point, whether it's a broader point about prioritizing measures that cut across settings or whether he focuses specifically on this measure, that I think would be an important point to make.

Kevin Larsen – Office of the National Coordinator

Okay.

Jim Walker – Chief Information Officer – Geisinger Health System

This is Jim, I do support that, it affects all kinds of settings, lots of patients, there is a lot of evidence, clear criteria for performance. It would be a good example of something that would make sense to consider including.

Eva Powell – National Partnership for Women & Families

Has there been any perceived push back on the medication reconciliation stuff in terms of removing the age ranges?

Kevin Larsen – Office of the National Coordinator

I've not heard anything to date. We've talked that over in part with CMS and have not heard anyone give any particular reason not to.

Eva Powell – National Partnership for Women & Families

Yeah, yeah, okay.

Tripp Bradd – Skyline Family Practice, VA

Eva, this is Tripp; I would happen to agree and I think I actually mentioned Jim by name as saying this is a very critically important, non-age-related measure.

Eva Powell – National Partnership for Women & Families

Right and I guess my thought process there is there is that if there is not push back to that and widespread agreement for the removal of age ranges then that might not be a priority to mention.

Kevin Larsen – Office of the National Coordinator

The only reason to mention it is if the NQF endorsed measure contains age ranges and there is sensitivity that changing the age ranges would mean that NQF would lose its NQF endorsement. Having that as a priority statement would intentionally inform that discussion.

Eva Powell – National Partnership for Women & Families

Okay.

Helen Burstin – National Quality Forum

Yeah and this is Helen Burstin from NQF as a matter of fact, we actually just reviewed the medication reconciliation measures as part of our care coordination project, there was a great deal of discussion about this age range issue as well as, just a lot of lack of clarity about who does it, what's included, just at discharge or not, I'm happy to share that with the group, but I think it would something that is still very much in play, I think that's an important consideration that could be considered.

Jim Walker – Chief Information Officer – Geisinger Health System

Yeah, this is Jim; I'd suggest calling it out. I mean, you think about if a kid actually had a medication list that means that they are among the highest risk and we know from the literature that managing pediatric medications is tricky for all kinds of reasons, getting the formulations right, making sure the concentrations are correct, is it teaspoons or milliliters, I mean it seems like a mistake to leave kids out of this.

Eva Powell – National Partnership for Women & Families

Right, so okay, it sounds like for the priority, in terms of the callout for the full committee, it would be there is widespread agreement that removing the age ranges is good, however we need to be mindful and work with NQF on implications to measure itself and whether that will enable endorsement or retaining of endorsement.

Helen Burstin – National Quality Forum

I actually think it's out for comment so if anybody wants to comment on that issue that would be great.

Eva Powell – National Partnership for Women & Families

Right, okay, I know the ADE issue, there is some strong sentiment, on the part of some at least, that it's critical to have this measure reflect an outcome, not just whether there was a check done, but more whether there was actually an ADE that occurred. So, that is probably the point to bring out.

Kevin Larsen – Office of the National Coordinator

So, that's in a way a theme we've had across these measures that the Workgroup has endorsed non-attestation measures.

Eva Powell – National Partnership for Women & Families

Right.

Kevin Larsen – Office of the National Coordinator

In favor of measures that truly measure the care or the outcome, is that correct?

Eva Powell – National Partnership for Women & Families

Yes.

Jim Walker – Chief Information Officer – Geisinger Health System

Jim Walker, the complication with warfarin is that the measure will be complex to record and report. I assume it will be something like percent of time in therapeutic range.

Kevin Larsen – Office of the National Coordinator

That is what we are currently looking at.

Jim Walker – Chief Information Officer – Geisinger Health System

That would require careful definition and then almost certainly require, well, vendors to do things they're not maybe all very good at or organizations to do some kind of custom build.

Eva Powell – National Partnership for Women & Families

Any other comments on that one? All right, moving on to 2.0 the alignment issue, I think it's really critical to point out here that alignment for the sake of alignment is not terribly useful, but we want to be sure we're aligning to the highest common denominator and not the lowest common denominator. So, I think there are a good number of folks who are concerned about aligning with PQRS because just the nature of that program is not terribly robust, but certainly the intent of alignment is a good one. Does that sound right to folks?

Kevin Larsen – Office of the National Coordinator

Yes.

Daniel Green – Centers for Medicare & Medicaid Services – Office of Clinical Standards and Quality – Health and Human Services

I have a question, this is Dan from CMS, what do you mean that the PQRS is not terribly robust?

Eva Powell – National Partnership for Women & Families

Well, and I'm going to speak a little bit out of school because I'm not intimately acquainted with the program, but from my understanding the reporting requirements are fairly minimal, it's something like three measures and there is a feeling that the particular measures in that program are not terribly useful and would not indicate Meaningful Use of Health IT. They are simply quality metrics.

Daniel Green – Centers for Medicare & Medicaid Services – Office of Clinical Standards and Quality – Health and Human Services

I would agree that they are quality metrics, but the one thing that PQRS does have is it has measures for many different types of providers and that are applicable to many different types of providers, you know, in terms of quality metrics necessarily measuring Meaningful Use, I mean that's I guess a little bit of a separate debate I would imagine. But, I just wanted some clarification. So thanks for clearing up what you meant.

Tripp Bradd – Skyline Family Practice, VA

Dan, this is Tripp, I think the conversation was also that PQRS was a one-way street, in other words Meaningful Use measures could use PQRS measures but not the other way around, in other words you couldn't meet CQM requirements in Meaningful Use with just PQRS, isn't that right?

Indiscernible-multiple speakers

Jesse James – Office of the National Coordinator

Yes, that is the next recommendation, exactly.

Daniel Green – Centers for Medicare & Medicaid Services – Office of Clinical Standards and Quality – Health and Human Services

Right, yeah, I'm not 100% sure but I thought that the proposed rule out there indicated differently but I could be mistaken.

Kevin Larsen – Office of the National Coordinator

Yeah, that's correct, the proposed rule suggests that testing to PQRS would qualify for Meaningful Use and this committee's comments have been that the Meaningful Use should qualify through PQRS, but because PQRS is not a program of electronic medical records you could do paper-based reporting and still get your Meaningful Use qualifications if you were using the PQRS methodology, therefore the Workgroup has said they did not like that component of the NPRM.

Daniel Green – Centers for Medicare & Medicaid Services – Office of Clinical Standards and Quality – Health and Human Services

Right, so just for clarification, and I don't want to hijack this and take us off track for the rest of the agenda, but I believe what was contemplated with respect to the PQRS folks could not report simply via paper claims, they would have to be…if they wanted to get credit for Meaningful Use CQMs they would have to be using an ONC certified product and report either directly from that EHR to CMS or they would have to report through a data intermediary which would be similar to a registry but one restricted to only getting data from ONC certified EHRs, so they couldn't just use claims or a web-based portal for a traditional registry if you will. Just a point of clarification.

M

Thank you.

Daniel Green – Centers for Medicare & Medicaid Services – Office of Clinical Standards and Quality – Health and Human Services

Thank you.

Jim Walker – Chief Information Officer – Geisinger Health System

This is Jim, it seems to me that one way to drive toward a single set of measures somewhere in the future in a way that would be minimally, whatever, disruptive or whatever, might be to say PQRS measures, if they are being reported in certified EHR and all, would be acceptable for Meaningful Use measures until a date certain. Was that discussed at all?

Daniel Green – Centers for Medicare & Medicaid Services – Office of Clinical Standards and Quality – Health and Human Services

We have looked at, again, you know, different time lines in terms of trying to…you know, obviously we're trying to reduce the reporting burden for eligible professionals, and at the same time, you know, in the PQRS program, we're moving toward a value-based modifier, so the information, you know, is becoming increasingly important, you know, in the past it's been just did you report above a certain threshold and if you did you're good to go. But, you know, as we move toward the value-based modifier, the information integrity becomes much more important. So, you know, we are looking, but at the same time we're also trying to be respectful of the eligible professionals and the requirements and burdens that they face. So, I can't give you a specific date but we are considering that.

Jim Walker – Chief Information Officer – Geisinger Health System

Okay, thanks.

Eva Powell – National Partnership for Women & Families

Okay, any others on that?

Kevin Larsen – Office of the National Coordinator

So, do we have a final language we want to be sure David gives to the Policy Committee? Just conceptually, Jesse and I can come up with something for David to review, but just a conceptual consensus.

Eva Powell – National Partnership for Women & Families

Yeah, well, I think from what I've heard in the conversation is that there is a universal desire to make these reporting programs increasingly robust, while also working to align things to minimize burdens for eligible professionals. So, the idea would be to ensure that whatever alignment has happened leads to greater levels of robustness as opposed to minimizing requirements for the sake of kind of checking a box as to whether or not a system can report these measures. And I think this has to do with…to some degree with perspectives on what specifically is the purpose of quality measurement in Meaningful Use and Meaningful Use to quality measurement, which is part of the discussion I'll bring up with my new idea. I mean, does that seem right to folks that we're in agreement that the idea is to achieve alignment, but not

for the sake of minimizing requirements necessarily, but making the requirements parsimonious and more and more robust?

Jim Walker – Chief Information Officer – Geisinger Health System

This is Jim, and I would add and create, you know, take every opportunity to create reasonable migration pathways, which make it clear we're getting to a unitary set of high, excellent quality measures, but, that we're going to do that in way that's mindful of the costs to organizations of getting there. You know, if an organization uses an EHR that has the PQRS measures already worked out and can report them out of its EHR I think there is a strong case to say, well, then let them do that until

2015 or 2014, or 2016, so that they know and their vendor knows that after this date it will not be usable any longer, but until then they can go ahead with that.

Eva Powell – National Partnership for Women & Families

Yeah, so that's kind of an interim suggestion until we can get to the point we are all after.

Jim Walker – Chief Information Officer – Geisinger Health System

Yeah.

Jesse James – Office of the National Coordinator

So, to summarize our thoughts, its alignment itself should be meaningful and we should align to measure robustness, decreased administrative burden and provision of evidence-based care, alignment should create reasonable pathways to a single suite of the CQMs.

Eva Powell – National Partnership for Women & Families

Right.

Jim Walker – Chief Information Officer – Geisinger Health System

Yeah.

Eva Powell – National Partnership for Women & Families

And when you say a single suite of CQMs what do you mean?

Jesse James – Office of the National Coordinator

Measure set, a single measure set.

Eva Powell – National Partnership for Women & Families

Okay, so just one specific list?

Jesse James – Office of the National Coordinator

Yeah, that is used by multiple programs.

Eva Powell – National Partnership for Women & Families

Right, right. Okay. All right, so moving on, expanding EP and EH eligibility. Let's see, any comments there?

Jesse James – Office of the National Coordinator

Well, just to explain the comment I added, so this was the recommendation discussed in the last call, this is Jesse, this is a recommendation discussed in the last call concerning adding long-term care facilities and behavioral health professionals and in reference to the behavioral health professionals, under the HITECH Act where they describe the EPs they list in particular physicians, NPs, rural or FQHC, PAs, and nurse midwives, and so there may be a statutory constraint that CMS has around what type of professionals can be identified as eligible.

Eva Powell – National Partnership for Women & Families

Right.

Jim Walker – Chief Information Officer – Geisinger Health System

And part of, this is Jim, part of LTPACs desire understanding that and this is, John Derr is a member of the Standards Committee, they understand the statutory limitation but, as I understand their position they would like to have quality measures and sort of start to get in the game even though there is no financial benefit to them.

Jesse James – Office of the National Coordinator

Okay.

Jim Walker – Chief Information Officer – Geisinger Health System

And particularly when you think of care coordination that's an obvious one.

Tripp Bradd – Skyline Family Practice, VA

Yeah, I think, this is Tripp with regard to care coordination it wasn't really calling out these particular institutions as eligible providers or institutions, isn't that correct?

Jim Walker – Chief Information Officer – Geisinger Health System

That's my understanding, yeah.

Eva Powell – National Partnership for Women & Families

Yeah, mine too. I think, at least the way I recall is that whatever we can do to encourage connections with non-eligible providers, we should because one of our major buckets is care coordination and hospitals and doctors will not coordinate care by themselves.

Tripp Bradd – Skyline Family Practice, VA

Right and Westley Clark said that, I think Westley's point with the behavioral health thing was well put, it was just to help with the coordination, this is Tripp again.

Eva Powell – National Partnership for Women & Families

Right, yeah.

Kevin Larsen – Office of the National Coordinator

Okay, so we'll change this from asking to expand the eligible provider group to asking to have measures that incorporate providers in these other settings and other settings into the measurement. Is that correct?

Eva Powell – National Partnership for Women & Families

Yes and I think it also has to do with our previous brief discussion about a falls risk, that the more we can do to have measures that cuts across settings the better. Am I right in that?

M

Yes.

Jim Walker – Chief Information Officer – Geisinger Health System

Yes, that's a perfect example.

Kevin Larsen – Office of the National Coordinator

Great.

Norma Lang, RN – University of Wisconsin

This is Norma Lang; may I ask a question about, what is the status of home healthcare in relationship to this point?

Eva Powell – National Partnership for Women & Families

I would see that as being included. Well, and I think the other thing to make clear to help people understand we're not suggesting that the incentive money be offered to these folks, but that these are settings and providers who are extremely important to the goal of care coordination and that we should encourage connections to all of them, whether that be nursing homes, behavioral health, home health.

Norma Lang, RN – University of Wisconsin

I would just like to see home health visible there.

Eva Powell – National Partnership for Women & Families

Yeah, I think it's important to list all the major categories of care settings.

Jim Walker – Chief Information Officer – Geisinger Health System

This is Jim; as I understand it, their term of…themselves is LTPAC and then we ought to…I think if we said LTPAC including but not limited to, because we'll miss something.

Eva Powell – National Partnership for Women & Families

Right. Okay, so moving onto provider or flexibility for reporting options. Any comments there? This is option 1A and 1B and honestly I think where we landed was 1A should be for primary care, is that right? And then 1B for specialists, or have I got that switched?

Kevin Larsen – Office of the National Coordinator

We've had a lot of different discussions and it was not exactly clear that this particular statement was the consensus of the group.

Tripp Bradd – Skyline Family Practice, VA

I think, Eva, this is Tripp, it was hard for people to fit in the conceptual framework of an option A and B and the other comment that was made, I think Peter Basch mentioned it or somebody did, was some of the specialists might have difficulties with a particular option so to speak.

Eva Powell – National Partnership for Women & Families

Yes.

Tripp Bradd – Skyline Family Practice, VA

And that was another thing that was brought up and really a melding or perhaps another option which might include both was another possibility, but I'm not going to say that.

Eva Powell – National Partnership for Women & Families

Yeah, well and that actually is exactly where my very new proposal comes in. So, first of all, I guess I'll ask the group, do we feel like we have to make a choice here or is it okay for us to say neither of these options are great, we can see pros and cons to both? Instead we'd like to offer a third option, if indeed there is a third option we would like to offer?

W

Is that the one you're going to suggest?

Eva Powell – National Partnership for Women & Families

Yes, I mean, I personally like it but then it's the world according to Eva, so we can talk about that, so if you want to table this and come back to it after we've had a chance to discuss that then that might be a good way to go.

Jim Walker – Chief Information Officer – Geisinger Health System

This is Jim; I just, you know, still being interested in hearing yours Eva. It seems to me this is a level of detail too fine for us to come up with a responsible recommendation and I would suggest we consider

some kind of recommendation that this be stated more generally and then that they, you know, have this group or some other group provide them additional feedback later on or something.

Eva Powell – National Partnership for Women & Families

Okay.

Jim Walker – Chief Information Officer – Geisinger Health System

I mean, it almost reads as silly, I mean is it going to be 12…11 in this or 11 in that and 12 of the other, 6 of this and 8 of that, I mean it sounds pretty arbitrary.

Eva Powell – National Partnership for Women & Families

Yeah.

Jim Walker – Chief Information Officer – Geisinger Health System

Yeah.

Kevin Larsen – Office of the National Coordinator

And there are a number of contingencies that we've discussed about the number of measures to make it into a final rule and the PQRS reporting, to my mind, are both that seem to may have influenced this.

Eva Powell – National Partnership for Women & Families

Okay. All right, let's move quickly through these last ones. Why don't we just take them as a group and folks can look quickly and just offer up whatever comments you have about 4.0 to 5.3.

Jesse James – Office of the National Coordinator

This is Jesse; just to explain the idea around the 5.0 to 5.3, this was to capture Eva's thoughts and your comments on a previous call about one having pilot measures, two having a forum for medical centers who develop their own measures on a national scale via Meaningful Use, and three having a platform for individual medical centers and providers to use their own measures inside of Meaningful Use.

Eva Powell – National Partnership for Women & Families

Yeah, okay, well this might then be a good place for me just to interject what I've been thinking and then we can discuss that and that would cover both of those sections. Let's see, let me get to my paper here so I cover this well. One of the things that has bothered me about quality measurement and Meaningful Use, aside from just trying to fit, to some degree, square pegs into round holes in terms of selecting from among the current measures and the current measures that have been converted to e-Measures and to some degree this is kind of step one in a long process and so that is understandable, but the thing that has bothered me the most is that I don't feel that we've that we've made much, if any, progress on leveraging the capabilities of an electronic records system to produce the new kinds of measures that we really absolutely must have if we're ever going to base payment on performance.

And that I think is a real lost opportunity that I would like to somehow work on and obviously I don't have the answer. But it seems that part of it also stems from the frustration of the length of time it takes to develop and endorse the measure, but then there are reasons for that and obviously if we're going to base payment on a measure we want it to be reliable and valid, and tested in the real world. So, there is some of that that we can't get around. But, I think that part of the frustration on my part has come in knowing that there are folks out there who are doing this iterative measurement development process continuously and yet we haven't figured out how to harness those efforts to funnel them into the measure endorsement process.

And so, the basis of my proposal here is just how can we retain the robust nature of the measure development process as we have it, but do that in a way that uses this iterative work that we know is happening as the testing so that we don't have this really long, drawn out measure development process and it would seem, in the context of Meaningful Use, would be the perfect place to do that because of course it's not just the issue of developing a measure, we're also in this kind of chasing our tails mode of the measures don't exist in large part because the technology doesn't exist to make them feasible. But,

then the technology is not going to exist to make them feasible if there are no measures that require those capabilities.

And, so it seems to me that since Meaningful Use is really not even a reporting program, because the data for quality metrics is not publicly reported, it's just a capacity kind of thing where providers are required to submit that information to CMS, but it's not publicly reported and payment is not based on it, and the whole purpose of the program is to implement Health IT that leads to Meaningful Use. So, it would seem that this program is the perfect setting and context in which to work on these two issues, the development of the measures we need for the future and the technology that's required to make them feasible.

So, my proposal is kind of like Jesse was saying, is there a way to build into Meaningful Use the Meaningful Use quality metrics reporting requirements a means of leveraging all of the work that's already happening? In other words, can we move from this measurement reporting model to a measure development model that either offers an option or just flat out says quality measurement and Meaningful Use is to help develop better quality measures and be able to report those? And, so the idea is…let me just scroll so I can talk about this a little bit more intelligently…is to require say EPs and EHs to submit five measures, and this is just kind of what this might look like, so that five measures, one for each measurement domain identified by the Quality Measurement Workgroup. If they're existing measures that are relevant and useful to providers in those five areas then they can submit those and so that would be more of a model like we've got now in using measures that exist. But, if there aren't then they still have to submit five measures, and they then either have to create their own measure or look to the leadership of their professional societies and trade associations to help them develop and test measures in each of those five areas.

And there are some things out there obviously that would help support this, namely the work that NQF has all ready done in developing the quality data model and the measure offering tool which is basically for this purpose. The idea here though is that we would just be expanding the measure development process to a wider range of people. And this also then obviously would cover the problem about specialists not having adequate measures that Peter brought up. If they don't have adequate measures then you've got to develop them. I mean, it's not like there is doubt about where our healthcare system is going. If you don't have measures, somebody's got to develop them and it might as well be you if you're going to be using them, because then you'll be bought in, it'll be assured to be relevant to your practice.

But, obviously we can't have 1000 flowers blooming in this effort, so we would need to set certain criteria for what would count as one of these measures and what wouldn't. And I think also, in order again, to get at the functionality component of this, we would have to lay out specific functionalities, and this is where I think the vendors and the tech folks can really be helpful to us is to provide enough specificity to the functionality so they get what we are talking about. But, just some examples here in terms of criteria that I would envision would need to be met by the measures would be that they would have to be outcome focused or process measures that are closely tied to outcomes. They have to be mapped to the QDM and HIT sensitive, it has to apply across multiple types of providers or care settings and that could be potentially an optional one.

It has to address an area of preventable burden and addressing health risk status and outcome. And then has to use at least one, if not more of, key functionalities that we would identify, and just my thoughts on what those key functionalities could be are just trying to think, you know, what are the

components of an EHR that need to be there to perform these measures and one would be this longitudinal tracking of information across time. One would be what I called assessment of appropriate medication and treatment as indicated by evidence-based clinical decision support and that may be a functionality that's already in some of these systems.

Reconciliation of data elements in an electronic record, stratification of data by identified variable, compilation of lists based on selected variables, tracking of longitudinal change that I've already mentioned, use of data across multiple data sources, comparison of one data element to another, identification of repeat tests and studies, calculation of composite measures, etc. Those are just

examples, it maybe that I've hit all the wrong examples, but I will kind of leave it there and just see first of all if that make sense whatsoever, and then if it does, what are your thoughts?

Tripp Bradd – Skyline Family Practice, VA

Eva, it's great, this is Tripp, you know, in the sense that you're encouraging development of clinical quality measures, as long as we don't suffer from diffusion of data.

Eva Powell – National Partnership for Women & Families

Right.

Tripp Bradd – Skyline Family Practice, VA

I think you mentioned 1000 flowers where they points of light or blooming flowers, I can't remember, but anyway, you know, the thing was though, that that is the risk.

Eva Powell – National Partnership for Women & Families

Yeah and I think…and something I didn't say that I need to be clear about is that my thinking here is not in any way meant to replace anything that is in existence, it's merely a way to get what's going on in the field, and to leverage that, which that is testing, it is testing and so to leverage the testing on the national scale so that our measure development process, well for any one measure I guess the length of time would be the same, but it's an ongoing iterative process as opposed to we've got this huge gap, let's, you know, start from scratch and fill the gap.

And so the idea, and this is a critical piece to making this work, is somehow connecting the testing components to the endorsement process so that at some point down the line there is a prioritization, a harmonization, and a standardization of measures so that ultimately the numbers of measures endorsed for anyone particular thing are relatively few. So, does that make sense?

W

Yes.

Jim Walker – Chief Information Officer – Geisinger Health System

This is Jim; I think if we said that, if we said that we want to capture measures that different providers, including for instance, LTPAC, find useful to measure their performance and feed those into the measure validation system that would be one thing, but, you know, among…if nothing else, if we don't do that, if we end up with a huge number of quality measures, they'll never get into EHRs.

Eva Powell – National Partnership for Women & Families

Oh, right, right.

Jim Walker – Chief Information Officer – Geisinger Health System

So it would only be the very largest organizations for whom this is any kind of option. I mean, we have hundreds, I suspect we have thousands of quality measures that we manage to, that we hold people accountable for, but, you know, you don't want that at a national level. Now if that fed into a group of candidate measures that then went through the process that would be probably okay.

Helen Burstin – National Quality Forum

Eva, this is Helen, can I just mention something about our proposed new process that I think might be really helpful here?

Eva Powell – National Partnership for Women & Families

Yeah, I thought that same thing.

Helen Burstin – National Quality Forum

Great, okay. So, we have proposed and have gotten preliminary go-ahead from our board to move to what we're calling a two stage endorsement process, we're actually hoping to conduct a pilot shortly and finalize this by early next year to begin for all projects, but essentially the idea would be to split the

endorsement process in two, initially the evaluation would be of measure constants meaning really what you want to measure without having the detailed specification and/or measure testing yet, but at least allow us to look at the underlying evidence for the measure focus, whether there is a gap in care, whether it's a high-priority area and understand what the proposed, for example data source would be. If somebody is planning to do that work in EHRs, this would apply to all measures, existing measures as well as newly submitted measures.

So, the second stage would be that if you passed that first stage you can then submit a fully tested and specified measure. Now, a couple of advantages we think to this, and we got this specifically from, you know, many of the developers out there including and actually CMS as well, as a suggestion, would be that we could actually have the concepts come in and then allow those developers to work together before they're fully specified and brought back in and fully tested. So that harmonization competing measures piece that kind of plagues all of us, we think will get really addressed by splitting it out in two.

And again, we can be letting people know who else is out there working in the same space and share that information so we don't have a lot of people out there doing work in the same space not even knowing that the others exist.

Eva Powell – National Partnership for Women & Families

Right, yeah and thanks for that clarification, Helen, because that's, in my mind, a key component of this as well because we obviously…if we're going to give federal incentive money to folks for submitting quality metrics, we don't want just some, you know, random generation of data, we want it actually to be useful. But, I mean, in my view, given the challenges that we are up against in the quality measurement arena, it would be a shame not to take advantage of the opportunity to essentially require testing of measures of every Meaningful User.

Helen Burstin – National Quality Forum

Correct.

Norma Lang, RN – University of Wisconsin

Eva, is there a way in which, this is Norma Lang, that we could write that into the recommendation with what you're proposing and what Helen just suggested is probably going to happen to give support to that?

Eva Powell – National Partnership for Women & Families

I think so and this is I think what David mentioned a little bit earlier in the call. I've written up just a description that is a little more cogent than what I just said verbally and what I'll do is clean it up a bit and then shoot it out to you guys for your added thoughts. The one thing, and I've not had a chance to look at the vendor document that came across, David seemed to think that it might fit with this, but what I haven't worked out in my own head is how might we make it an advantage for a technology vendor to play in this game? Because, again, a key goal of this is to not just to build the measures, but to build the technological capability of generating the measure.

And so, potentially, it's kind of the 1000 points of light or 1000 flowers blooming thing again is if a vendor is going to support this approach, then they potentially are signing up to write codes for every potential measure known to man, which I'm guessing is not something they're really up to do. But, if we could figure out that piece then this might really have legs and so I'll shoot out what I've got once I've had a chance to clean it up, and you all add to it and we'll make it part of our recommendation, because I just don't see how, given the current approach, the quality measurement and Meaningful Use, how we're going to ever build the capability of having really good care coordination measures, because you can't do that without exchange of information across data sources and you know, those kinds of things that I just haven't seen progress on in terms of the technology, and maybe I'm just not talking in the right circles, but anyway.

So, it sounds like there is some thought that this might be workable if we can clean it up and answer some questions, is that right?

Helen Burstin – National Quality Forum

This is a Helen; I'm happy to review that specific language if I can help.

Eva Powell – National Partnership for Women & Families

Yeah, that would be great. I'll send that to you as part of my cleanup to get you whatever details I'm missing on the stuff that you guys are doing.

Jim Walker – Chief Information Officer – Geisinger Health System

So, Eva, are you proposing these measures would feed into a measurement development system or that they would be reportable as quality measures before they fed into the system?

Eva Powell – National Partnership for Women & Families

Well, it depends on what you mean as reportable. I think what I am suggesting is that the reporting requirement for Meaningful Use have a measure development purposes as opposed to a reporting requirement because they're not being publicly reported so why do we care that they are reported to CMS?

Jim Walker – Chief Information Officer – Geisinger Health System

Well, no, I mean reported for payment. This is Jim. I would argue strongly that no measure should be reported to CMS or anybody else for payment, anyone federal unless it's gone through the full measure development and validation process.

Eva Powell – National Partnership for Women & Families

Yes, if what you're talking about is performance on the measure. But, I'm not sure why we wouldn't use this development opportunity since the incentive is only for the action of sending the data to CMS. Why can we not use that as a testing ground for new measures?

Jim Walker – Chief Information Officer – Geisinger Health System

Well, think of the cost to an organization. So, as I said, we already collect and report thousands probably, certainly high hundreds, and does that mean then that we're going to submit those to CMS, in what format, using what standard vocabularies, using what kind of data dump, how is CMS going to receive them and do anything with them? I think there are all kinds of feasibility issues with what you're suggesting that would require some discussion before we recommend that it be enshrined in a NPRM.

Eva Powell – National Partnership for Women & Families

Yeah, well I think you're right, there definitely are a lot of questions and obviously we wouldn't expect an organization to submit thousands, it would be…to me the benefit to provider organizations would be we would keep this at a minimum. So, you know, your choice is to submit five measures that you develop yourself or submit 24 that have no meaning to you and what is your better option there and what is…?

Jim Walker – Chief Information Officer – Geisinger Health System

Well, but the point is that the 24 have meaning to the country and to Americans who have health care problems and that's the point. See if you're saying…if your proposal is that an organization could say we don't want to send in validated ones, we'll send in ones of our own, I think that is a terrible idea.

Eva Powell – National Partnership for Women & Families

Yeah, well and I think again it gets back to the purpose of quality measurement and Meaningful Use not all of the measures that are being reported nationally have meaning for the country, and this program frankly, the quality measurement piece of this program doesn't have meaning for the country because it's not being reported.

Jim Walker – Chief Information Officer – Geisinger Health System

No, no, no but the point is that the measures have been validated as having meaning to the health of the population.

Eva Powell – National Partnership for Women & Families

Right, right.

Jim Walker – Chief Information Officer – Geisinger Health System

If you let people pick the five that they like, I'll guarantee you personally that they won't have any relevance to anything except the convenience of the people sending them in.

Eva Powell – National Partnership for Women & Families

Yeah, well that's why it would be really important to come up with some really strong criteria and parameters for what counts and what doesn't, because I think that, even though they may not be validated, has value to the country in the sense that it's a necessary part of a process to get to better measures.

Jim Walker – Chief Information Officer – Geisinger Health System

But if you have criteria, who is going to measure the measures against the criteria and confirm that they met the criteria? You're back to a validation process.

Kevin Larsen – Office of the National Coordinator

So, this is Kevin, I wonder if we can look to the clinical decision support requirement in MU1 as an example where organizations were required to do a clinical decision support intervention but we didn't really specify more than the basic parameters of what that was.

Eva Powell – National Partnership for Women & Families

Yeah, that's a good point. And Jim, your question is a good one because obviously that's got to be part of this too and I think that's part of what Helen's suggestion was is that is that NQF could serve that role through the new process they're already developing.

Jim Walker – Chief Information Officer – Geisinger Health System

Yeah, but the point is someone is going to have to…if that's not part of the standard validation process, if it's a new parallel validation process, someone is going to have to pay for it.

Eva Powell – National Partnership for Women & Families

Yeah. Well, why don't we get some of this cleaned up and better explained, and I'll work with Helen some on that to better explain the work that they're already doing and how that might fit in with this and then we'll send it for your further clarification and questions and comment, because like I said I have my own questions that I know would need to be worked out. I just don't see that we're providing any value whatsoever to the quality measurement of our nation through Meaningful Use if the exercise is only to prove that we can make technology spit out the measures we have today.

First of all, that doesn't in any way support what we need for value-based purchasing, it doesn't support the new models of care that we're moving toward, and we've got to somehow get past this impasse and this is just one idea and it's again, not fully fleshed out, but I think it is a start and it has a number of components that are going on in other places that would I think support it. So, we'll get you something and definitely, you know, mark it up, you know, give your comments and questions, and think about other roadblocks there might be so that we can start working around them.

W

Would you expect you to get that out today or tomorrow, is what you are suggesting?

Eva Powell – National Partnership for Women & Families

Yeah, I think, Kevin, didn't you say you were going to try to get a summary packet out today and this will be part of it?

Kevin Larsen – Office of the National Coordinator

Yes, we will.

W

Okay, thank you.

Kevin Larsen – Office of the National Coordinator

Do want to move to the Tiger Team report?

Eva Powell – National Partnership for Women & Families

Sure, we've got, I think…are we ending at noon? Is that right?

Kevin Larsen – Office of the National Coordinator

I have us scheduled until 1:00 but I don't think that most people want to be on that long. So, I could do this really fast.

Eva Powell – National Partnership for Women & Families

Okay, yeah, yeah, I just wanted to be mindful of time, but yes, if we've got until 1:00 go right ahead.

Kevin Larsen – Office of the National Coordinator

So, as you remember we commissioned a Tiger Team of vendors and had a pretty rapid turnaround and got a good representation from a number of vendors, they put forward their candidate. And we had David lead that group, we met earlier this week and he was really challenging them to help us understand how we can best have a flexible model of reporting from the vendors. So, if you open up this vendor Tiger Team recommendations I put in about 9 bullet points of the items that they've identified and they're very similar to things that we've heard from other places. I can run through them quickly.

The first one is they felt that we should have consistent value sets across measures wherever possible, that this would really help them be flexible in their measure reporting infrastructure and they'd ideally like to have these present before the measures are actually developed and written as opposed to getting them with the measures or after the measures. And an interesting one, number two, they felt that for many organizations that capture both…like-measures and MU measures it was very important that billing codes be contained within the Meaningful Use measure so that they can continue to report both in a consistent way. They really liked the idea of measures being developed de novo in EHRs as opposed to having retooled measures, because they found the retooled measures are actually difficult to implement for a number of reasons that were outlined there.

They would like some better measurement outputs that are more efficient to input into electronic medical records. And number five is a really interesting one, they would like suggested workflows for measures. They find that when the measures come with a specific ask or requirement, but not a recommended way that should happen, that they have to invent it and they would like that to be part of the recommendation with how the measure comes to them. They asked for a way to be able to test the measure against real production data. And then they talked about a couple of different kinds of testing that they were really speaking toward the challenges that they hear from their customers as their customers want to implement these measures. And, they said that they get a lot of pushback from customers that while this makes it really hard for me to do care, it's taking a lot of extra time. So, they were talking about kind of a usability testing of the measure, how does it impact the workflow and the usability of the clinician?

And then something that I labeled for them, implementability, which is not exactly the same as feasibility, it is that time and cost, and burden it would take to implement this measure, maybe it has a 35 item survey that would need to be captured at each and every point of care that would have a great big burden of implementation even though it would be feasible. They like the idea of field testing measures before they're included into a program and they really would like that any survey measure can actually leverage data that already exists in the record as opposed to the survey having to ask that question again because of some…whatever technical or survey integrity reasons. So, that's a quick drive through of what they suggested. Comments or questions about that?

Tripp Bradd – Skyline Family Practice, VA

This is Tripp, having just been in a, if you will, a focus group, if you will, for a vendor with people trying to interpret the rule, and then coming around to what they should develop their software around, I think, you know, five and seven speak to that greatly. Implementability, excuse me it doesn't roll off my tongue very well, really if it's not easy for the person or provider to do it's not feasible for them either. I think they're probably synonyms in terms of the end user, but also for the vendor, you know, what's feasible for them too, but that is one of the things that goes back to parsimony and everything else. Do you all let the vendors under the hood prior to coming out with the measures or do they just have to…it seems like they're on their own to develop it after the fact, and I think that's what they're complaining about, is that correct?

Kevin Larsen – Office of the National Coordinator

That is correct. The federal rules are quite clear that what's in the NPRM is in the NPRM and what's in the final rule is in the final rule and if there is work that's being done between those two the public has access to what's in either the NPRM or the final rule. So, the ongoing measurement development work now is happening with the contractors, but there's nothing final that the vendors can be building on now anyway.

Tripp Bradd – Skyline Family Practice, VA

Yeah, my sense was, excuse me, was that, you know, sometimes the vendors are looking at that tea leaves and trying to make sense of it. I like the two-stage process of NQF just to use it as an example, you know, having the vendors involved, or at least knowing what's going on at an interim step so to speak so they can be developing the processes prior and I think that's the big complaint they all had, at least from one of the vendors is was there was never time or energy, or resource available to really get them out in a reasonable way.

Helen Burstin – National Quality Forum

Right and this is Helen again, I think building on that point, I think the other advantage would be as well that there is no reason at all that…for example measure developers couldn't collaborate with vendors as the actually e-specify those measures and bring them forward. We would actually hope to do that and actually Kevin and I have been having some conversations and have a meeting coming up shortly to talk through this issue of, you know, what is feasibility testing, what does it mean on our end, what does it means for ONC and trying to aligning some of those definitions and I think implementability is an important consideration.

Interestingly, in the old paper world, I know it seems like the stone ages, many of the measure developers would come forward with actually a measurement algorithm that allowed people to actually understand the workflow of where would you would find, where would you find this piece of data? So, it might be something we may want to think through in terms of how that's applicable to e-Measures.

W

Could I ask for clarification of who is a vendor, are these the large groups, are these the small boutique vendors? When you said you met you met with vendors could you just give me a little bit of an idea?

Kevin Larsen – Office of the National Coordinator

Certainly, for this initial call we reached out to the…I won't get the name exactly right, it's the vendor…there is a vendor professional group, a vendor collaborative organization.

Jim Walker – Chief Information Officer – Geisinger Health System

It's EHRA.

Kevin Larsen – Office of the National Coordinator

EHRA, so we reached out to EHRA that is chaired by Carl Dvorak and we asked Carl as the head of

EHRA to identify their key constituents and then asked those vendors to submit a candidate to be part of the Tiger Team. So, it represents the larger of the EHR vendors and really the EHR vendors that are

most Meaningful Use connected. There is discussion about expanding that to some other kinds of vendors, smaller vendors, cloud based vendors, registry vendors, but this was the focus because they were the ones most impacted by MU1 and therefore likely the ones that had the most specific feedback about the NPRM.

W

Thank you.

Kevin Larsen – Office of the National Coordinator

To David's point, are there any concepts from here that the group would like to raise, have him raise at the HIT Policy Committee meeting?

Jim Walker – Chief Information Officer – Geisinger Health System

This is Jim, I have a question. On number 3B there should be fewer exceptions was this on the assumption that the exceptions were required, that documentation of the exceptions was required?

Kevin Larsen – Office of the National Coordinator

So, what the vendors talked about is that when the exceptions come into the measures sometimes there will be 30 or 50 possible exceptions, they then have to build a workflow for the providers to be able to capture those at the point of care. And the more complex the exceptions are and the more varied those exceptions are the much more challenging it is to build tools that lets providers make those exceptions at the point of care.

Jim Walker – Chief Information Officer – Geisinger Health System

Well, from a provider's stand-point it looks sort of the opposite. I mean, first if they're optional some providers could say well, there is not enough of that exception in our population, we're not going to collect it. But, if there are enough of whatever the exception is in their population, patients on palliative care, then they could decide okay, it's worth it to us to document that exception, because otherwise we won't make the 80%. So, you know, I think it might be worth calling out that on 3B there may be difference of perspective between vendors and their customers. And that's the whole point of the exception is not dinging providers for doing things to patients that would be inappropriate.

Tripp Bradd – Skyline Family Practice, VA

Was this around software design, I have to ask the question around 3B, was it that users would have to create, if you will work arounds to the software to make the exceptions work, is that another issue?

Kevin Larsen – Office of the National Coordinator

Yes, there was not good workflow integration. So, for example, if you have a palliative care exception for a patient, how do you annotate that in the record that for this particular automatically generated measure this patient is called out?

Jim Walker – Chief Information Officer – Geisinger Health System

Yeah, but the point is again, if it isn't worth it to the provider to figure out how to document it, then that's fine, if it's optional they can say it's not worth the trouble we're not going to mess with it. But the point is if they do need to, it's available to them so they can use it. And that's the question is whether this is seen as mandatory or something that you can decide whether it's worth the trouble or not.

Kevin Larsen – Office of the National Coordinator

Yeah, I think their primary point is that they felt like most of the measures were built for a retrospective analysis of those exceptions and to build tools to have providers do it at the point of care, felt really challenging, how to designate this patient is in a research protocol, therefore it is an exception to this. Each and every doctor at the point of care needs to do that, as opposed to a chart reviewer reading all the charts after their care is done.

Jim Walker – Chief Information Officer – Geisinger Health System

Well, but again if there's nothing in the rule that says it needs to be done at the point of care and of course some of us would never do it at point of care or almost never. It seems to me they are reading in all kinds of things that are not in any part of any rule, you know, they're not mandatory, they don't have to be done at the point of care, many of them are based on problem lists for instance or other things that would be recorded normally in the EHR anyway. So, I think we just should…before we pass that one on as this group's understanding of things, we ought to make sure we have thought through all the dimensions of what their reluctance was.

W

I would support that. I would like to also return to 3A if we could for a moment, that one is full of challenges and it has a relationship to B, but they would really would like value sets, data types and terminology standardized. How far along are we with…I mean, we can't really even settle it seems on the ICD and SNOMED and other things that are kind of plaguing us to have an interoperable data set. So, yeah that would be nice, but how far along are we and where would we like to put our energies in that regard?

Jim Walker – Chief Information Officer – Geisinger Health System

This is Jim, the Standards Committee transmitted to ONC last September a set of recommendations on a standard vocabulary for all the elements of the quality data model. The value set work is underway, although it's far from complete. So, there is considerable shape to identifying and developing those tools, although it's far from complete.

W

Well, if you're going to look at measures coming in, would you expect that they would be tied to standardization? Are we moving towards like every data element would have HL7 approval? I haven't seen those or else I don't recall your recommendations from your standards group and so maybe it's not an appropriate question here, but it seems…

Jim Walker – Chief Information Officer – Geisinger Health System

Well, the recommendation is more like if the measure requires a problem list, that would be SNOMED, you know, if it requires a medication that would be NCPDP, you know, RX Norm, that kind of…it's at that level.

W

Oh, okay, well that's standard.

Kevin Larsen – Office of the National Coordinator

And with the value sets so that's going to be atomic level, the value sets are looking at the molecular level. So, if we're looking for diabetes on a problem list, SNOMED is the way we want the terminology to be used. But, they're looking for what are all of the SNOMED concepts that equal diabetes and how many different measures can that same set of SNOMED concepts exist in, because right now each measure may have its own set of concepts that equal diabetes.

Jim Walker – Chief Information Officer – Geisinger Health System

Right. Yeah, the value sets are not as far along as the vocabulary recommendations.

Kevin Larsen – Office of the National Coordinator

And again, this was in context to David challenging them, what would it take for your systems to be more flexible in doing measures? And they said the more that you can give us standard components before the measures, the more flexible our systems can be.

Jim Walker – Chief Information Officer – Geisinger Health System

Sure.

Kevin Larsen – Office of the National Coordinator

Each measure is a custom creation, the more we're going to have to hardcode it to custom create that within our system.

Tripp Bradd – Skyline Family Practice, VA

This is Tripp, with regard to four was that an answer to simplifying or standardizing the output with XML is that the intention there?

Kevin Larsen – Office of the National Coordinator

Yeah, they're excited about the HQMS, the things they got for Meaningful Use 1 were narrative descriptions of measures and they had to do a lot of analysis and interpretation to figure out how to take those narrative descriptions and make them computer code. So, the more work that is done about that before they get the measures delivered to them as a vendor, the more consistent they feel like their measures will be from one vendor to the next and the less time it will take them to build them, and so the more flexible capacity they'll have. But, we don't certainly need to bring this at all to the Health IT Policy Committee or we could just bring components. Is there anything in here that the group feels they'd like to make sure David brings forth?

Tripp Bradd – Skyline Family Practice, VA

This is Tripp, my thought would be they should see this, because this is telling them how hard it was, if you will, for the vendors to make this happen and they need to be mindful of that. Given Jim and everyone else's comments on it, I think the less we alter it, perhaps even the better.

Jim Walker – Chief Information Officer – Geisinger Health System

This is Jim, I agree.

Kevin Larsen – Office of the National Coordinator

Great.

Eva Powell – National Partnership for Women & Families

Sounds good.

W

I would agree.

Kevin Larsen – Office of the National Coordinator

Eva, I don't know if we want to go back to the things that we parking lotted in the response, but those are…if we did that already.

Eva Powell – National Partnership for Women & Families

Let's see, so you're talking about 4.0 to 5.3?

Kevin Larsen – Office of the National Coordinator

Yeah.

Eva Powell – National Partnership for Women & Families

That spreadsheet? Well, I'm not sure we addressed like the timetable issue, we didn't necessarily address. Could you explain what you mean by that?

Kevin Larsen – Office of the National Coordinator

Jesse are you there?

Jesse James – Office of the National Coordinator

Yeah, I was on mute, sorry.

Eva Powell – National Partnership for Women & Families

That's all right. So, the timetable, it looks like it's based on the need for feedback from previous stages, but what exactly…and I apologize, I'm not good at reading on the fly, what is the proposal?

Jesse James – Office of the National Coordinator

The proposal is essentially for earlier feedback and earlier description. This was a recommendation that was discussed, it wasn't completely fleshed out in the earlier meeting, but it also was mentioned in the recommendations after Stage 1.

Eva Powell – National Partnership for Women & Families

Okay.

Jesse James – Office of the National Coordinator

So the recommendation was that CMS be more deliberate and besides having a final rule and then waiting until an NPRM to describe their measures, the suggestion was either an intermittent letter and interval or releasing the NPRM earlier and earlier on their own timetable than previously intended.

Eva Powell – National Partnership for Women & Families

So, the idea is to know the specifics behind the measures earlier so that vendors can have more time.

Jesse James – Office of the National Coordinator

Right or even if not the specifics, to allow a description of the concepts earlier.

Eva Powell – National Partnership for Women & Families

What do folks think about that? I mean, what should our summary point be?

Jim Walker – Chief Information Officer – Geisinger Health System

This is Jim, maybe we could generally say something like we urge that any information can be given to them as early as it's available including topics, standard vocabularies, value sets, whatever the other thing they mentioned and that was…I think that's the issue, if ONC/HHS were fastidious about communicating everything that they knew as soon as they could and was appropriate brackets around, you know, what's been decided and what is still in the planning stage, I think that's what they're looking for.

Jesse James – Office of the National Coordinator

Okay.

Jim Walker – Chief Information Officer – Geisinger Health System

Appropriately.

Eva Powell – National Partnership for Women & Families

Okay.

Jim Walker – Chief Information Officer – Geisinger Health System

You know, it's like when you're an airplane and they say we're going to be delayed, if they come back on in 20 minutes and say, you know, things are looking pretty good we're thinking another 15 minutes, you can just feel like everyone on the plane relax.

Eva Powell – National Partnership for Women & Families

Yeah.

Jim Walker – Chief Information Officer – Geisinger Health System

Nobody expects it to be perfect or final.

Eva Powell – National Partnership for Women & Families

Yeah. So, like an interim rule.

Jim Walker – Chief Information Officer – Geisinger Health System

Yeah or just interim indications or whatever, you know, whatever they need to call it so that it's appropriately, you know, so that there are appropriate disclaimers around it, it still would still help them to understand how things are moving.

Eva Powell – National Partnership for Women & Families

Okay. Kevin, is that good enough do you think for…?

Kevin Larsen – Office of the National Coordinator

Yeah, that's great.

Eva Powell – National Partnership for Women & Families

Okay, so the last one then is the accelerating design development testing of eCQMs. We kind of talked about that with my proposal but let's see if there are other stuff here that is not. This kind of also fits with what Jim was just saying too that…so, I don't know, what do folks feel about these items? Should we come up with a statement now or just wait up until Kevin can send the stuff around and have David present that?

Kevin Larsen – Office of the National Coordinator

It sounds like there aren't strong feelings.

Eva Powell – National Partnership for Women & Families

Yes. So, maybe what we can say then is consider an alternative to 1A and 1B and here's an alternative that, you know, we thought through and you can consider and the specifics of that obviously will reflect the input of the group based on what Kevin will send out later.

Kevin Larsen – Office of the National Coordinator

Yes.

W

That sounds good.

Eva Powell – National Partnership for Women & Families

Okay, well good. Is there any other business other than…?

Kevin Larsen – Office of the National Coordinator

No, those were the items we intended to cover.

Public Comment

Eva Powell – National Partnership for Women & Families

Okay, very good, all right, well do we want to open it up for public comment then?

MacKenzie Robertson – Office of the National Coordinator

Sure. This is MacKenzie. Operator can you please the lines for public comment?

Caitlin Collins – Altarum Institute

Yes. If you are on the phone and would like to make a public comment please press *1 at this time. If you are listening via your computer speakers you may dial 1-877-705-2976 and press *1 to be placed in the comment queue. We do not have any comments at this time.

Eva Powell – National Partnership for Women & Families

Very good, well I guess we're done then. Kevin do you have any last comments.

Kevin Larsen – Office of the National Coordinator

No, thank you all for all the hard work; it's been a lot of time on the phone, so thank you very much.

Jim Walker – Chief Information Officer – Geisinger Health System

Thank you for your hard work.

W

Thanks everybody.

W

Thanks.

MacKenzie Robertson – Office of the National Coordinator

Hold on, Kevin?

Kevin Larsen – Office of the National Coordinator

Yes?

MacKenzie Robertson – Office of the National Coordinator

Sorry, I don't know if everyone has dropped off, I was just wondering if it would be helpful to go through the timeline for comments back to you and all that one more time just so everyone can hear it?

Kevin Larsen – Office of the National Coordinator

So, you mean that we would do the…we'll turn something out today and then we'll ask for the weekend so that by Monday David can have something to put into the document for Wednesday.

MacKenzie Robertson – Office of the National Coordinator

Yeah.

Kevin Larsen – Office of the National Coordinator

We can just send that out with the materials I think.

MacKenzie Robertson – Office of the National Coordinator

Okay.

Eva Powell – National Partnership for Women & Families

So, comments by Monday, a specific time Monday, close of business or…?

Kevin Larsen – Office of the National Coordinator

MacKenzie, do you know?

MacKenzie Robertson – Office of the National Coordinator

The comments need to be to Michelle by 10 a.m. Monday.

Kevin Larsen – Office of the National Coordinator

Okay.

MacKenzie Robertson – Office of the National Coordinator

So, however you want to work the timeframe of people giving feedback back to you on the document you plan on sending out today.

Kevin Larsen – Office of the National Coordinator
All right, so we'll get that…Jesse and I will work on that.

MacKenzie Robertson – Office of the National Coordinator
Okay.

Jesse James – Office of the National Coordinator
We'll just put the details in an e-mail this afternoon.

MacKenzie Robertson – Office of the National Coordinator
Okay.

Kevin Larsen – Office of the National Coordinator
Yeah. Great.

MacKenzie Robertson – Office of the National Coordinator
All right thanks.

Eva Powell – National Partnership for Women & Families
Thanks, guys.

Kevin Larsen – Office of the National Coordinator
Thank you, bye-bye.

Public comment Received During the Meeting

1. Our organization would like to stress that the government (CMS & ONC) must get a quality measure reporting mechanism in place as part of increasing the total number of measures that EPs, EH/CAHs are required to report. The reporting requirements to multiple organizations must be streamlined also. Lastly, all measures selected in the future for reporting from the EHR must be vetted for all data elements actually being in the EHR. The amount of manual extraction of data is a hindrance to quality reporting. Also, this manual extraction of data is counter to the desire for electronic reporting from the EHR. Thank you.